State: *Arkansas* ***Filing Company:*** *Old American Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *A2890 - Application*
Project Name/Number: *A2890 - Application/A2890*

Filing at a Glance

Company:	Old American Insurance Company
Product Name:	A2890 - Application
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	10/03/2012
SERFF Tr Num:	KCLF-128683003
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	A2890
Implementation Date Requested:	On Approval
Author(s):	Bobby Stow
Reviewer(s):	Linda Bird (primary)
Disposition Date:	10/08/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: Arkansas **Filing Company:** Old American Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: A2890 - Application
Project Name/Number: A2890 - Application/A2890

General Information

Project Name: A2890 - Application
Project Number: A2890
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Bobby Stow

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 09/17/2012
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 10/08/2012
State Status Changed: 10/08/2012
Created By: Bobby Stow
Corresponding Filing Tracking Number:

Filing Description:

With this filing, Old American Insurance Company is submitting for review and approval A2890-AR, Application for Life Insurance. The Medical Information Bureau, MIB, has mandated a change to the Authorization found on the second page. The required change has been made to previously approved A2887-AR to comply with the MIB mandated change. A2887-AR was approved by the Arkansas Department of Insurance on March 28, 2011.

The Authorization contained on the second page has been amended to include the MIB required change. The following sentence has been added to the Authorization: "I authorize Old American Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB." No part of the application has been altered or changed, and remains identical to the previously approved A2887-AR.

Company and Contact

Filing Contact Information

Bobby Stow, Compliance Analyst I
3520 Broadway St.
Kansas City, MO 64111

bstow@kclife.com
816-753-7299 [Phone] 8852 [Ext]
816-753-3018 [FAX]

Filing Company Information

Old American Insurance Company
3520 Broadway
PO Box 218573
Kansas City, MO 64121-8573
(816) 753-4900 ext. [Phone]

CoCode: 67199
Group Code: 588
Group Name:
FEIN Number: 44-0376695

State of Domicile: Missouri
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $50.00
Retaliatory? Yes
Fee Explanation: Missouri retaliatory fee.
Per Company: No

Company	Amount	Date Processed	Transaction #
Old American Insurance Company	$50.00	10/03/2012	63358762

SERFF Tracking #:	*KCLF-128683003*	***State Tracking #:***		***Company Tracking #:***	*A2890*

State:	*Arkansas*	***Filing Company:***	*Old American Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*A2890 - Application*		
Project Name/Number:	*A2890 - Application/A2890*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/08/2012	10/08/2012

SERFF Tracking #:	*KCLF-128683003*	***State Tracking #:***		***Company Tracking #:***	*A2890*

State:	*Arkansas*	***Filing Company:***	*Old American Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*A2890 - Application*		
Project Name/Number:	*A2890 - Application/A2890*		

Disposition

Disposition Date: 10/08/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Cover Letter		Yes
Form	Application for Life Insurance		Yes

SERFF Tracking #:	*KCLF-128683003*	***State Tracking #:***		***Company Tracking #:***	*A2890*

State:	*Arkansas*	***Filing Company:***	*Old American Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*A2890 - Application*		
Project Name/Number:	*A2890 - Application/A2890*		

Form Schedule

Lead Form Number: A2890

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		A2890-AR	AEF	Application for Life Insurance	Initial:	48.100	A2890-AR.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

APPLICATION FOR LIFE INSURANCE TO: OLD AMERICAN INSURANCE COMPANY

3520 Broadway • P.O. BOX 218573 • KANSAS CITY, MISSOURI 64121-8573

FR:AP1211

OWNER'S NAME_____
FIRST NAME INITIAL LAST NAME

PLAN

☐ BMQ ☐ BMS 20 ☐ BMP - Single ☐ Level 20 - Single
☐ BMS ☐ BMS 10 ☐ POM – Guaranteed
☐ IBL 10 ☐ IBL 20 ☐ _____

ADDRESS _____ **PHONE #** _____
CITY _____ **SSN** _____
STATE _____ **ZIP** _____

AMOUNT OF PREMIUM FOR APPLICATION $_____ ☐ **Annual** ☐ **Semiannual** ☐ **Quarterly** ☐ **P.A.P.**

First Insured's Name**					Relationship to Owner S.S.N.			*Primary Beneficiary – Relationship
Plan	Amount	ABR ☐ CTR ☐ ADB ☐ WPNH ☐	Sex	Height	Weight	Place of Birth (State)	Date of Birth	*Contingent Beneficiary – Relationship
Second Insured's Name					Relationship to Owner S.S.N.			*Primary Beneficiary – Relationship
Plan	Amount	ABR ☐ CTR ☐ ADB ☐ WPNH ☐	Sex	Height	Weight	Place of Birth (State)	Date of Birth	*Contingent Beneficiary - Relationship

*Unless otherwise stated benefits are payable equally to the named beneficiary(s) or to the survivors or survivor.

HEALTH QUESTIONS - Below, the word "you" refers to all persons to be insured listed above.	**PERSON TO BE INSURED** First	Second
1. Have you been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for HIV?	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you had: **a.** a stroke or heart attack in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
b. congestive heart failure in the past 36 months?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you had or been treated for cancer (other than skin cancer) at any time in the past 24 months or have you ever been diagnosed as having cancer of the lung?	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you used home oxygen in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
5. In the past 12 months have you been hospitalized two or more times for the same disease/disorder; or been confined to a nursing facility; or received home health care or in the last 30 days needed assistance performing regular activities of daily living (ADL) such as bathing; dressing; eating; taking medications; or moving about?	☐ Yes ☐ No	☐ Yes ☐ No
6. In the past 24 months have you had liver disease including cirrhosis, kidney failure, kidney dialysis or renal insufficiency or alcohol or drug abuse?	☐ Yes ☐ No	☐ Yes ☐ No
7. Do you have: **a**. diabetes diagnosed before age 40 and requiring use of insulin?	☐ Yes ☐ No	☐ Yes ☐ No
b. any chronic lung disease, including chronic asthma, chronic bronchitis, emphysema, chronic obstructive pulmonary disease or tuberculosis?	☐ Yes ☐ No	☐ Yes ☐ No
8. Have you had a stroke, heart attack, angina or any other heart or circulatory disease in the past 24 months?	☐ Yes ☐ No	☐ Yes ☐ No
9. Have you ever been declined, rated, or postponed for life insurance?	☐ Yes ☐ No	☐ Yes ☐ No
10. Have you used any form of nicotine/tobacco in the past 12 months? (cigar, pipe, smokeless tobacco, cigarettes, nicotine patch, nicotine gum)	☐ Yes ☐ No	☐ Yes ☐ No
11. Have you had: **a.** Ulcerative colitis or Crohn's disease?	☐ Yes ☐ No	☐ Yes ☐ No
b. Alzheimer's disease, senility, Parkinson's disease or brain tumor (benign)?	☐ Yes ☐ No	☐ Yes ☐ No
c. Multiple sclerosis or paralysis?	☐ Yes ☐ No	☐ Yes ☐ No
12. Do you have diabetes?	☐ Yes ☐ No	☐ Yes ☐ No
a. Was diabetes diagnosed before age 40?	☐ Yes ☐ No	☐ Yes ☐ No
b. Do you require the use of insulin?	☐ Yes ☐ No	☐ Yes ☐ No
13. Have you ever sought advice, been treated or arrested for the use of alcohol or drugs (including prescription drugs)?	☐ Yes ☐ No	☐ Yes ☐ No
14. Have you had in the past 5 years: **a.** Cancer (other than skin cancer)	☐ Yes ☐ No	☐ Yes ☐ No
b. Heart attack or stroke	☐ Yes ☐ No	☐ Yes ☐ No
15. In the past 12 months have you been diagnosed as having high blood pressure or has your blood pressure medication changed?	☐ Yes ☐ No	☐ Yes ☐ No
16. Have you had arthritis or a bone, joint or muscle disorder in the past 36 months which necessitated surgery or use of a wheelchair or walker?	☐ Yes ☐ No	☐ Yes ☐ No

HEALTH QUESTIONS (continued)	PERSON TO BE INSURED First	PERSON TO BE INSURED Second
17. In the past 24 months have you: **a.** had a body scan, CT scan or MRI?	☐ Yes ☐ No	☐ Yes ☐ No
b. been confined to a nursing home or long term care facility?.....	☐ Yes ☐ No	☐ Yes ☐ No
c. been advised to have surgery or other treatment?	☐ Yes ☐ No	☐ Yes ☐ No

Initials of First _____ Initials of Second _____

Personal Doctor for First Insured Name:	Street address:	City	State	Zip Code
Personal Doctor for Second Insured Name:	Street address	City	State	Zip Code

AGENT'S SECTION

If you believe special consideration should be given to either applicant, please give details of all questions answered yes.

Question#	Date and Nature of Diagnosis or Treatment	Name and Address of Treating Physician/Hospital

OTHER INSURANCE

If issued, will this policy replace or change any other life insurance or annuity you now carry? If your answer is yes, give details on a separate sheet of paper, including name of insurance company. .....

PERSON TO BE INSURED First	PERSON TO BE INSURED Second
☐ Yes ☐ No	☐ Yes ☐ No

AUTHORIZATION

I(we) authorize the following to give information (defined below) to Old American Insurance Company or any person or group acting on the part of Old American Insurance Company: any medical professional, medical care institution, the Medical Information Bureau, Inc., insurer, reinsurer, government agency, consumer reporting agency or employer. I authorize Old American Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. "Information" means facts of: a medical nature regarding my physical or mental condition; employment; other insurance coverage; or any other non-medical facts. I(we) understand that this information will be used by Old American Insurance Company to determine eligibility for insurance. I(we) agree this Authorization is valid for two and one-half years from the date signed. I (we) know that I(we) have a right to receive a copy of this Authorization upon request. I(we) agree that a photographic copy of this Authorization is as valid as the original.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AGREEMENT AND SIGNATURE

The statements and answers given in this application are true and complete. They are deemed to be representations and not warranties. Unless otherwise stated in a receipt of the Company issued in exchange for the first premium, this coverage shall take effect on the Effective Date shown in the policy, only if it is delivered to the Owner and the first premium is paid during the Insured's lifetime. I(we) acknowledge receipt of the Notice with Regard to the Medical Information Bureau. **I(we) understand that the agent is not authorized to accept risks or pass on insurability, to make or modify contracts or waive the Company's rights and requirements including the requirement that the adult proposed insured(s) personally sign this application in the agent's presence. *PLEASE NOTE:*** *Before signing, read and review your answers for accuracy.*

Signature of **OWNER** _____ Date _____ Signature of First Insured - if other than owner _____ Date _____

Signature of Second Insured - if other than owner _____ Date _____

SPECIAL INFORMATION OR REQUESTS

**If the Insured is different than the Owner please provide the address and phone number of the Insured.

☐ **Check box to draft initial premium.**

☐ **Please check box if you request the policy be sent directly to the Agent.**

Automatic Premium Loan _____ Yes _____ No

Application number _____ of _____

AGENT'S CERTIFICATION

I hereby certify that, to the best of my knowledge, the insurance hereby applied for **( ) will ( ) will not** replace any existing insurance. I further certify that: (1) the above answers are full, complete and true to the best of my knowledge; (2) I know of no factors affecting the insurability of the proposed insured(s) except as stated; and (3) the above signatures are those they are represented to be and were signed in my presence.

Licensed Agent _____ Code Number _____

Agency _____ Code Number _____

Signed At _____ City _____ State _____

All premium checks must be made payable to Old American Insurance Company. Do not make check payable to the agent or leave the payee blank.

SERFF Tracking #:	*KCLF-128683003*	***State Tracking #:***	***Company Tracking #:*** *A2890*

State:	*Arkansas*	***Filing Company:***	*Old American Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*A2890 - Application*		
Project Name/Number:	*A2890 - Application/A2890*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Filing Certification - Arkansas.pdf Readability Certification - Arkansas.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Cover Letter		
Comments:	Attached is a cover letter that describes the filing.		
Attachment(s):			
Cover Letter - Arkansas.pdf			

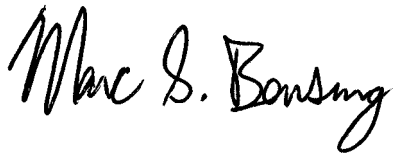
STATE OF ARKANSAS
COMPLIANCE CERTIFICATION

COMPANY NAME: Old American Insurance Company

FORM TITLE(S): Application for Life Insurance

FORM NUMBER(S): A2890-AR

I hereby certify that to the best of my knowledge and belief, the above form and submissions is in compliance with Regulation 19, Regulation 49, and all other laws, rules and regulations of the State of Arkansas.

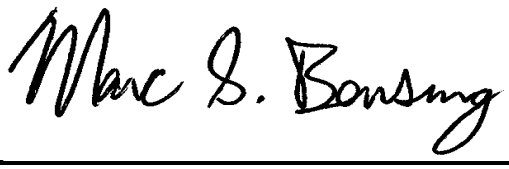


Marc S. Bensing
Assistant Vice President
Old American Insurance Company

October 2, 2012

READABILITY CERTIFICATION

Form	Score
A2890-AR	48.1



Name: Marc Bensing
Title: Assistant Vice President
Company: Old American Insurance Company
Date: September 13, 2012

OLD AMERICAN
INSURANCE COMPANY
3520 Broadway • PO Box 218573 • Kansas City, Missouri 64121-8573
Telephone: (816)753-4900

September 13, 2012

Arkansas Department of Insurance
1200 W. Third Street
Little Rock, Arkansas 72201-1904

RE: Old American Insurance Company
NAIC: 67199-588
FEIN: 44-0376695
Form Filing: MIB mandated change to Application for Life Insurance

Dear Sir or Madam:

With this filing, Old American Insurance Company is submitting for review and approval A2890-AR, Application for Life Insurance. The Medical Information Bureau, MIB, has mandated a change to the Authorization found on the second page. The required change has been made to previously approved A2887-AR to comply with the MIB mandated change. A2887-AR was approved by the Arkansas Department of Insurance on March 28, 2011.

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Please direct all inquiries regarding this filing to me at the address, phone number, or email address contained in the file.

Sincerely,

Bobby Stow
Compliance Analyst
Old American Insurance Company
Phone: 800.821.6164
Ex: 8852
Email: bstow@kclife.com